Churchland Family Medicine, P.C.

Patient Health History

Patient Name_____ Date of Birth_____

Past Medical History – Please place a check mark next to any of the conditions that apply;

Anxiety Disorder _____

Arthritis _____

Asthma _____

Cancer _____

COPD _____

Coronary Artery Disease _____

Depression _____

Diabetes _____

Diverticulitis _____

Fibromyalgia _____

GERD/Reflux _____

Gout _____

Heart Disease _____

High Cholesterol _____

Hypertension _____

Hyperthyroidism _____

Hypothyroidism _____

Kidney Disease _____

Kidney Stones _____

Liver Disease _____

Osteoporosis _____

Pulmonary Embolism _____

Stroke _____

Tuberculosis _____

Social History

Do you smoke? Yes_____ No_____
If yes, how long? _____ How Much?_____

Do you drink alcohol? Yes_____ No_____
If yes, how much and how often?_____

Any illicit drug use? Yes_____ No_____

Caffeine? Yes_____ No_____
If yes, how much and how often?_____

Chewing Tobacco? Yes_____ No_____
If yes, how much and how often?_____

Number of Children _____

Do you have a Living Will?_____

Family History

Father
If alive, current age_____ If deceased, Age at death_____
Cause of Death_____
Medical Condtions_____
_____

Mother
If alive, current age _____ If deceased, Age at death _____
Cause of death_____
Medical Condtions_____
_____

Siblings
If alive, current ages _____
If deceased, causes of death_____

Surgical History

Please list any previous surgeries you have had and the date the surgery was performed;

_____

_____

_____

Drug Allergies

Please list any medications that have caused an allergic reaction and list type of reaction;

_____

_____

Other Physicians

Please list any other doctors that you are currently seeing and the reason you are seeing them;

_____

_____

Medication

Please list all medications you are currently taking, including over the counter;

_____

_____

_____

_____

_____

_____

Pharmacy

Please provide the name of your local pharmacy of choice, including the address and phone number;

_____

If you receive medication through the mail, please provide your mail-order pharmacy including address and phone number;

_____